TO THE EDITOR, *Genitourinary Medicine*

Chlamydial infections and human papillomavirus lesions in women with cervical intraepithelial neoplasia

Sir,

Dr K Syrjanen and colleagues, in their interesting paper on chlamydial infections (*Genitourin Med* 1986;**62**:345-51), really must amend their last sentence. That a sexually transmitted agent is commonly found in these women with cervical intraepithelial neoplasia because of their promiscuous behaviour is true, but equally it must also be pointed out that it is very often the result of the promiscuous behaviour of their male partners.

Yours faithfully,
J K Oates

Department of Genitourinary Medicine,
Westminster Hospital,
London SW1P 2AP

TO THE EDITOR, *Genitourinary Medicine*

Human immunodeficiency virus (HIV) antibodies in Greenland

Sir,

The epidemiology of the acquired immune deficiency syndrome (AIDS) in central Africa differs from that in Europe and the USA. In central Africa AIDS is equally distributed between men and women,[1-5] whereas in Europe and the USA it is found primarily in homosexual men, parenteral drug addicts, and recipients of blood products. The incidence of sexually transmitted disease (STD) in central Africa is high, and heterosexual promiscuity seems to be the most important factor for the widespread transmission of the human immunodeficiency virus (HIV).

The population of Greenland is about 50 000, and so far there have been no verified cases of AIDS, though we know of three HIV antibody positive men who contracted the infection in Copenhagen. The incidence of STD in Greenland is high, as reflected in an incidence of syphilis that is 100 times higher than in Denmark and other western countries. The high morbidity of STD is primarily due to promiscuity of certain groups. If the HIV infection is introduced in Greenland, the experience of Africa would lead us to expect the infection to disseminate quickly among men, women, and children.

To discover whether HIV has been introduced in Greenland, all serum samples submitted for syphilis serological testing during January 1986 were analysed for antibodies against HIV. The patients were informed that testing was being undertaken, but 78 refused to participate and 25 were not tested because of insufficient serum. A total of 1639 serum samples from 677 men and 893 women were analysed. The median age of all patients was 31 (range 0-83) years. The samples originated from all major villages in Greenland except the district of Thule. All samples were tested by an enzyme linked immunosorbent assay (ELISA) using disrupted crude HIV virus as antigen. ELISA positive samples were analysed by the western blot technique using highly purified HIV virus as antigen and by an immunofluorescence test using HIV infected lymphocytes as antigen.

Thirty (1·9%) patients were found reactive for HIV antibodies in the ELISA, but only two samples, both from women, were doubtfully reactive in the western blot test, reacting weakly with only the major core protein, p24. Further blood samples from both women were analysed and found negative. None of these samples reacted in the immunofluorescence test. In the population studied 18 (1%) were found to have active syphilis and 271 (17%) had been treated previously for syphilis, which indicated that the population was a high risk group for STD.

Denmark, which has one of the highest incidences of AIDS in Europe, has very close contacts with Greenland, and it is somewhat surprising that we did not find any HIV antibody positive person. The infection has probably not yet been introduced into Greenland, perhaps because of a low prevalence of homosexuality. It is very important that efforts are taken to reduce the high incidence of STD, as this will also reduce the potential risk of dissemination of the HIV infection.

Yours faithfully,
*N Strandberg Pedersen**
*E Lauritzen**
B Ørskov Lindhardt†

*Treponematoses Department and the AIDS Laboratory, Statens Seruminstitut, DK-2300 Copenhagen S, Denmark
†Laboratory of Tumor Virology, Fibiger Institute, DK-2100 Copenhagen O, Denmark.

References

1. Clumeck N, Sonnet J, Taelman H, *et al.* Acquired immunodeficiency syndrome in African patients. *N Engl J Med* 1984;**310**: 492-7.
2. VandePerre P, Rouvroy D, Lapage P, *et al.* Acquired immunodeficiency syndrome in Rwanda. *Lancet* 1984;ii:62-5.
3. Piot P, Quinn TC, Taelman H, *et al.* Acquired immunodeficiency syndrome in a heterosexual population in Zaire. *Lancet* 1984;ii:65-9.
4. VandePerre P, Carael M, Robert-Curoft M, *et al.* Female prostitutes a risk group for infection with human T-cell lymphotropic virus type III. *Lancet* 1985;ii:524-7.
5. Kreiss JK, Koech D, Plummer FA, *et al.* AIDS virus infection in Nairobi prostitutes. Spread of the epidemic to East Africa. *N Engl J Med* 1986;**314**:414-8.

TO THE EDITOR, *Genitourinary Medicine*

Sexually transmitted diseases in rape victims

Sir,

In their paper on the incidence of sexually transmitted diseases in rape victims (*Genitourin Med* 1986;**62**:267-9) Forster *et al* showed that about 30% of such women may have sexually transmitted disease. Though the source could not confidently be traced to the alleged rapist in all cases, this finding is very disturbing. The rapid spread of the human immunodeficiency virus (HIV) into the heterosexual community means that all rape victims must be considered to be at risk for the acquired immune deficiency syndrome (AIDS), particularly in view of the observation that rape is becoming more violent and more often includes such acts as anal and oral penetration. This danger to rape victims was sadly not discussed. Should not all alleged rape victims be screened initially and at three months for HIV antibody, so that conversion can be detected and transmission to the victim's husband or sexual partner be prevented? In addition, if a patient could prove that HIV had been contracted during rape, there would be important medicolegal consequences.

Yours faithfully,
L A Kay

Department of Haematology,
Royal Infirmary,
Sunderland SR2 7JE.